ARIZONA DEPARTMENT OF ECONOMIC SECURITY

DIVISION OF DEVELOPMENTAL DISABILITIES

BILLING MANUAL

May 2006

SFY06 BILLING INSTRUCTIONS FOR DIVISION PROVIDERS

General Purpose of this Instruction

The purpose of this document is to provide assistance and clarification to providers on billing documents and the processes that are necessary in order to file a proper billing claim.

All providers are encouraged to utilize the Division's electronic billing process. The advantage of utilizing the electronic submission is an expedited processing of claims for services and review of any denials of those claims resulting in more timely payments. The file layout requirements are posted to the Division's WEB site. **Training may be arranged through Judy Niebuhr.**

Judy Niebuhr is the Division's Accounts Payable Manager. She can be contacted via email at JNiebuhr@azdes.gov or via phone at 602-542-6798, (toll free at 1-866-229-5553).

Additionally, the Division offers **direct deposit**. All providers are encouraged to fill out the direct deposit forms to use the direct deposit option. The advantage to a provider is that they receive payments 2 to 5 days quicker than through the mail.

The Direct Deposit form titled "ACH Vendor Authorization Form GAO-618 ACH" and the instructions are posted to the Department of Administration: www.gao.state.az.us. On the left side of their site go to "Vendor and ACH Info". Then near the bottom of the new screen go to: "ACH Vendor Authorization (GAO-618) Form" and "Instructions – ACH Vendor Authorization (GAO-618)".

Complete the form per the instructions – but - DO **NOT** SEND IT BACK TO THE DEPARTMENT OF ADMINSITRATION AS INSTRUCTED ON THE FORM. INSTEAD SEND THE COMPLETED FORM TO:

Judy Niebuhr, Site 791A
Accounts Payable
DDD Business Operations
1789 W. Jefferson, 4th Floor
Phoenix, AZ 85007

Allow sixty days for processing your request.

For all published billing rules in the service specifications of the (QVA) contract, refer to the Division's Website. For Non-published - billing rules are governed by specific contract.

Billing documents are auditable and legal documents, and must be completed and signed by all parties to be processed.

Vendors have a choice of two billing methods: (A) Electronic, or (B) Paper.

A. ELECTRONIC BILLING:

1. **Definition:** Electronic Billing is the process of billing the Division in accordance with the Electronic Import Specification.

   All services, delivered on behalf of a specified consumer and paid through the Division of Developmental Disabilities can be included on your billing disk.

If you are interested in converting to the electronic system, contact Judy Niebuhr at: 602-542-6798 (toll free at 1-866-229-5553) or email **JNiebuhr@azdes.gov.**

2. **Only One Disk may be submitted to the Division per month:** When utilizing the Electronic Billing System, you may only submit one disk to the Division per month. This disk:
   - can include all districts,
   - may include all re-bills for the current fiscal year, and,
   - may include original bills.

   You should bill either entirely on disk or paper, **but not both.**

   You may include multiple months within the same fiscal year on a disk, and multiple districts on the same disk.

   You may not bill for future services.

3. **Where to submit disk:** Submit your disk to:

   Judy Niebuhr, Site 791A
   Accounts Payable
   DDD Business Operations
   1789 W. Jefferson, 4th Floor
   Phoenix, AZ 85007

4. **Billing Segments:** You are required to bill on a different line for any breaks in continuous days of service, when rates change or when the Individual Service Plan changes.

   For example, if you are billing for Day Treatment and Training for a consumer that goes from Monday through Friday with no break in service (from the 1st to the 5th of the month), you may bill on one line from the 1st to the 5th.

   You will need to bill a new billing segment (line) for the next week from the 7th to the 11th, if there was no break in services for that time period and so forth

   If a consumer is absent for one day, say on the 3rd, you will need to bill from the 1st to the 2nd on one line; (you cannot bill for absent units except for Room and Board) so the next segment (line) would be from the 4th to the 5th, and so on.

If there is a change in the Individual Service Plan, a new billing segment is required. For example, if the current Individual Service Plan goes through June 15th and a new one starts June 16th, you will need to bill one segment from June 1 through June 15 if there were no breaks in service - and a new segment for June 16th forward.

The total daily number of units of service for that billing segment, multiplied by your hourly rate will give you the total for that billing segment

For all published rate services, your rate can be found on the DDD website. www.azdes.gov/ddd/.

Click on - "For Important Vendor Information",
then – "For General Information About Qualified Vendors",
then – "Rates",
then – "RateBook".

For non-published rate services, your contract "Price Sheet" determines your billing rate.

As an example of a published rate service: You were providing HAI – Habilitation, Independent Setting - from the 1st to the 5th; 5 days at 2 hours per day for a total of 10 hours.

You are providing this service to two consumers at the same time (1:2 staffing ratio).

In September of 2005 the billable rate was $11.61/hour per consumer.

Your bill should show 2 hours each day for 5 days for each consumer on two separate lines.

This totals to 10 hours (x) times your rate of $11.61 for a total of $116.10 for the five-day billing segment for each consumer.

When doing the math, always round up. For example: if the calculated number is $6.345, round to $6.35, not $6.34

Each break in continuous dates of service, whether a weekend, absence or a holiday would require a new billing segment.

NOTE: All Respite, whether continuous (daily) or short term (hourly) must be invoiced by date of service.

For Therapy Services and Nursing - if the family has private insurance and you have not been issued a waiver by the Division, a hard copy of the Explanation of Benefits must be attached.

5. **Invoice Sheet**: You **are** required to complete the invoice cover sheet. This form: "Monthly Invoice Cover Sheet", is available on the WEB site.

B. PAPER BILLINGS – Two Formats: (1) Uniform Billing Document (UBD Short Form), and (2) Date of Service / Uniform Billing Document (DOS / UBD Long form).

1. **Definition:** Non-electronic submittal of a claim in the Division's approved Short or Long Form format. Instructions and copies of these forms are located at the end of this document

2. **One Billing Document per Month**: When utilizing the paper billing, you may only submit one bill to the Division per month. This bill may include all districts and re-bills as well as original bills. You should bill either entirely on disk or paper, but not both.

   You may include multiple months within the same fiscal year on a bill, and multiple districts on the same bill.

   Billing documents must be completed in blue or black ink and submitted in paper format, no pencils or white out will be permitted. Bills not completed in full, signed and dated, will be returned for completion and resubmission.

   Note: Bills may <u>not</u> be FAXed

   You may not bill for services not yet provided.

3. **Where to Submit your paper bills:** Submit your paper bill to:

   Judy Niebuhr, Site 791A
   Accounts Payable
   DDD Business Operations
   1789 W. Jefferson, 4th Floor
   Phoenix, AZ 85007

4. **Billing Segments:** You are required to bill on a different line for any breaks in continuous days of service, when rates change or when the Individual Service Plan changes.

   For example, if you are billing for Day Treatment and Training for a consumer that goes from Monday through Friday with no break in service (from the 1st to the 5th of the month), you may bill on one line from the 1st to the 5th.

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The total daily number of units of service for that billing segment, multiplied by your hourly rate will give you the total for that billing segment.

For all published rate services, your rate can be found on the DDD website. www.azdes.gov/ddd/.

Click on - "For Important Vendor Information",
then – "For General Information About Qualified Vendors",
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5. **Invoice Sheet**: You **are** required to complete the invoice cover sheet. This form: "Monthly Invoice Cover Sheet", is available on the WEB site.

C. ACCOUNTS PAYABLE CONTACTS

If you have any questions when preparing your FY06 billing, please direct your questions to Judy Niebuhr**.** She can be contacted via email at JNiebuhr@azdes.gov or via phone at 602-542-6798, (toll free at 1-866-229-5553).

D. DOCUMENTS REFERENCED IN THE BILLING MANUAL

1) **Monthly Invoice Cover Sheet - to be attached to both paper and electronic bills.**
2) **Instructions for Uniform Billing Document (Short Form), Including Place of Service Codes.**
3) **Uniform Billing Document (Short Form)**
4) **Instructions for the Date of Service/Uniform Billing Document (Long Form)**
5) **Date of Service/Uniform Billing Document (Long Form)**
6) **Professional Billing System and Electronic Import Specifications, Version 1.0**

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
1789 W. Jefferson - P.O. Box 6123 - Site Code 791A - Phoenix, Arizona 85005
Janet Napolitano **Division of Developmental Disabilities** David A. Berns
Governor Telephone: (602) 542-0419 Fax: (602) 542-8193 Director

MONTHLY INVOICE COVER SHEET

FROM:_____CONTRACT NO:_____

CONTACT PERSON:_____

PROVIDER ID:_____PHONE NUMBER:_____

ADDRESS_____

CITY_____STATE_____ZIP_____

MONTH ENDING_____TOTAL AMOUNT BILLED $_____

I certify that the information contained in the attached invoice is correct and is prepared in accordance with the terms of this contract.

PROVIDER SIGNATURE DATE

Claims should be submitted to the person specified in Part C, Accounts Payable Contacts

Monthly Invoice Cover Sheet – to be attached to both paper and electronic bills.

INSTRUCTIONS FOR UNIFORM BILLING DOCUMENT (Short Form)
Not Respite

1. **PROVIDER NAME:** Provider name as contracted with ADES/DDD.
2. **FEI / SSN:** Provider's Federal Employer Identification # or Social Security Number
3. **PROVIDER OF SERVICE AHCCCS ID**: For Group Billers, enter the direct service provider's AHCCCS ID.
4. **MONTH/YEAR OF SERVICE:** The month and year that is being billed. One month per billing document.
5. **SERVICE:** The service that is being billed. One service per billing document.
6. **CONTRACT NUMBER:** The Provider's contract number. The contract number must correspond to the fiscal year that bills are submitted.
7. **DISTRICT:** Circle the appropriate District to be billed for this service.
8. **PROV LOC:** Two letter providers **Location Site Code** where service was delivered. (e.g. AA, AB, etc.)
9. **ASSISTS CONSUMER ID:** This is the ASSISTS consumer identification number assigned by the ADES/DDD.
10. **CONSUMER NAME/LAST:** The consumer's last name.
11. **CONSUMER NAME/FIRST:** The consumer's first name.
12. **SVC START DATE:** First day service was delivered (MM/DD/YY)
13. **SVC END DATE:** Last day service was delivered (MM/DD/YY).
    (If there is a break in consecutive days of service, you need to use a new line)
14. **SVC CODE:** The three-character code that designates the service authorized and delivered. NOTE: Please use only one service code per page.
15. **P.O.S:** Place of Service code, enter the two digit code that indicates the **type of setting** where the service was delivered.

TWO DIGIT CODE	TYPE OF SETTING
11	Office
12	Patient's Residence (home, ADH, CDH, group home, IDLA, etc)
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
54	Intermediate Care Facility/Mentally Retarded
56	Psychiatric Residential Treatment Center
99	Other Unlisted Facility (e.g. park, transportation, store, etc)

16. **DELIVERED UNITS:** Enter the number of units delivered.
17. **NO SHOW/ABSENT UNITS:** Enter the number of absent units (RSA services only) or no show units (therapy treatments only). (Absent or No Show units billed for services other than RSA or therapy treatments will be cause to reject bill.) Indicate billable no show as NS; and billable absent as A otherwise leave blank.
18. **TOTAL UNITS:** Enter the total number of units. This is the total of number 16 and number 17.

19. **RATE:** Enter the contracted rate per unit/hour for the service.
20. **TPL CODE:** Third Party Liability Code, do not fill in. The ADES/DDD representative will complete. NOTE: For all consumers having insurance, please include an Explanation of Benefits (EOB) that corresponds to the service and date delivered or a waiver.
21. **TPL AMT:** Third Party Liability Amount, do not fill in. The ADES/DDD representative will complete.
22. **TOTAL (ROW):** Enter the total dollar amount billed (billed units/hours x rate = total amount).
23. **SITE RATE COUNT:** Enter the number of individuals sharing the service at common site, and common time. (i.e. RSP 3 persons multiple consumer. rate for each would be 3. Group home will be number of individuals sharing the day. If absent, still include in number. If vacant, don't include in number.)
24. **BUDGET SOURCE CODE:** ADES/DDD use only. The ADES/DDD representative will complete.
25. **TOTAL (COLUMN):** Located in the bottom right corner. Enter the total dollar amount of this column for this page only.
26. **CERTIFICATION STATEMENT:** The Preparer and the Provider must certify to the correctness of the invoice by providing signature, date and telephone number.
27. **TOTAL BILLING AMOUNT SUBMITTED UNDER THIS INVOICE:** Enter the total amount of all pages.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
DIVISION OF DEVELOPMENTAL DISABILITIES
UNIFORM BILLING DOCUMENT (Short Form)

Bill I.D. Number: _____

3. PROVIDER OF SERVICE AHCCCS ID# (THERAPIES ONLY) _____ PAGE _____ OF _____

1. PROVIDER NAME: _____ 4. MONTH/YEAR OF SERVICE: _____ 6. CONTRACT #: _____

2. FEI / SSN: _____ 5. SERVICE: _____ 7. District: I II III IV V VI VII VIII

8 PROV LOC	9 ASSISTS CLIENT ID	10 CLIENT NAME (LAST)	11 CLIENT NAME (FIRST)	12 SVC START DATE	13 SVC END DATE	14 SVC CODE	15 POS	16 DEL UNITS	17 NO SHOW/ ABSENT UNITS	18 TOTAL UNITS	19 RATE	20 TPL CODE	21 TPL AMT	22 TOTAL	23 SITE RATE COUNT	24 BUDGET SOURCE CODE

25. TOTAL: _____

26. I certify that the information contained in this billing document is true and correct and has been prepared in accordance with the terms of the contract.

_____ PREPARER'S SIGNATURE & DATE

_____ PREPARER'S NAME & TELEPHONE NUMBER

27. $ _____ TOTAL BILLING AMOUNT SUBMITTED UNDER THIS INVOICE

_____ PROVIDER'S SIGNATURE & DATE

_____ PROVIDER'S NAME & TELEPHONE NUMBER

_____ DDD SIGNATURE & DATE PROCESSED

CLAIM #: _____ CLAIM #: _____ CLAIM #: _____

INSTRUCTIONS FOR DATE OF SERVICE / UNIFORM BILLING DOCUMENT
(Long Form - must be submitted on legal size paper)

1. **PROVIDER:** Provider name as contracted with DES/DDD.

2. **FEDERAL EMPLOYER IDENTIFICATION/SOCIAL SECURITY NUMBER:** Provider's Federal Employer Identification
   Social Security Number.

3. **ADDRESS:** Provider address.

4. **GROUP AHCCCS ID:** The Provider's group AHCCCS ID number.

5. **INDIVIDUAL PROVIDER AHCCCS ID:** For Group Billers, enter the direct service provider's AHCCCS ID.

6. **CONTRACT NUMBER:** The Provider's contract number. This contract # must correspond to the fiscal year that bills are submitted.

7. **SERVICE:** The service that is being billed.

8. **MONTH/YEAR OF SERVICE:** The month and the year that is being billed.

9. **BUDGET SOURCE:** Please leave this area blank.

10. **PROVIDER LOCATION:** Two letter providers **Location Site Code** where service was delivered. (e.g. AA, AB, etc.)

11. **CONSUMER NAME**

12. **CONSUMER ASSIST ID**: This is the ASSISTS consumer identification number assigned by the ADES/DDD.

13. **INDIVIDUAL DATES OF SERVICE:** Do not fill in with an X. Enter the **number** of units delivered for each specific date of service. If daily unit, enter 1 for each service delivery date; if hourly unit, enter number of service hours delivered each day.

14. **POS:** The Place of Service code. The two-digit code indicates the **type of setting** where the service was delivered.

PLACE OF SERVICE:

TWO DIGIT CODE	TYPE OF SETTING
11	OFFICE
12	PATIENT'S RESIDENCE (home, ADH, CDH, Group Home IDLA, Etc.)
22	OUTPATIENT HOSPITAL
31	SKILLED NURSING FACILITY
32	NURSING FACILITY
33	CUSTODIAL CARE FACILITY
54	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
56	PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
99	OTHER UNLISTED FACILITY (E.G., PARK, STORE, TRANSPORTATION, ETC.)

15. DELIVERED UNITS: Enter the number of units delivered.

16. NO SHOW/ABSENT Units: Enter the number of absent units (RSA services only) or no show units (therapy treatments only). (Absent or No Show units billed for services other than RSA or therapy treatments will be cause to reject bill.). Indicate billable no show as NS; and billable absent as A, otherwise leave blank.

17. TOTAL UNITS: Sum of Column 15 and Column 16.

18. SERVICE CODE: The 3-digit service code that corresponds to the service being billed under #7 above.

19. TPL CODE: For TPL Billing ONLY: Third Party Liability Code. NOTE: For all consumers having insurance, please include an Explanation of Benefits (EOB) that corresponds to the service and date delivered or a waiver.

20. TPL AMOUNT: For TPL Billing ONLY: Third Party Liability amount paid by insurance company. This amount is deducted from the amount to be paid by the Division.

21. RATE. Published Rate for service delivery or contracted rate for non-557 services.

22. TOTAL: Enter the total dollars for line. Units **times** Rate (less TPL amount if applicable)

23. PAGE TOTAL. Total all of column 22.

***PREPARER'S and PROVIDER'S SIGNATURES:** The signature of the individual preparing this invoice.

***DATE:** The date on which the preparer signed the invoice.

NOTE: Uniform Billing Documents will only be accepted after the last date of service for the month billed. It must be submitted on 8.5 X 14 legal size paper

DO NOT SHRINK DOWN TO 8.5 X 11 SIZE PAPER

The Date of Service / Uniform Billing Document (Long Form) is available only in Excel format. It must be submitted on 8.5 X 14 size legal paper. A copy of this Excel form is attached with the Billing Manual.

Professional Billing System Electronic Import Specification, Version 1.0

Electronic Input

Electronic bills can be accepted by the DES / DDD Professional Billing System (PBS). Electronic bills must be submitted as follows:

- 3 ½" floppy disk delivered to the DDD Accounts Payable Unit.
- Only 1 file must be submitted per disk.
- File must reside in root of the disk.
- Filename must be in the correct format as specified below.
- File contents (header, detail, trailer) must be in correct format as specified below.

File Naming Standard

All providers must be issued a 4-character PBS provider code for use in the file name and identification in the database. This usually a code based on the name of the provider and is unique to the PBS. If a provider does not know their code they should contact the DDD prior to file submission.

Current Fiscal Year:
For a billing for the current State Fiscal Year, the file name must be in format:

XXXXYYMM.txt

where XXXX is provider code, YY is year, MM is month.

Ex: PROV0311.txt – Provider: PROV for November FY 2003

Resubmission

A resubmission is an invoice for the previous State Fiscal Year. These files are validated the same as current State Fiscal Year invoices, except that the Month and Year naming convention on the file is slightly different.

file name must be in format:

XXXXRRRB.txt

where XXXX is provider code, RR is the sequential resubmission number, and RB stands for rebilling.

Ex: PROV02RB.txt – Provider: PROV , second rebilling for FY 2002 (assuming the current FY is 2003)

File Format:

Header Line

- Must be the first line in the file
- Line Layout

Description	Type*	Format	Length	Start Position	Values
REC_INDICATOR	AN	AA	2	1	HR
FILE_MONTH	AN	AAA	3	3	JAN thru DEC, RS1 thru RS9
FILE_YEAR	N	NN	2	6	Current or Previous State FY
PROVIDER_ID	AN	XXXXXXXXX	9	8	

For a resubmission, the Month in the file header and detail will be RS# where # is a value of 1 thru 9 (i.e. RS1, RS2, etc.) indicating the sequential rebilling number from the filename. For a resubmission, the Year in the file header and detail is the previous State Fiscal Year.

Trailer Line

- Must be the last line in the file
- Line Layout

Description	Type*	Format	Length	Start Position	Values
REC_INDICATOR	AN	AA	2	1	TR
REC_COUNT	N	NNNNNNNNNNN	12	3	
TOTAL_UNITS	N	NNNNNNNNN.NN	13	15	
TOTAL_TPL_AMT	N	NNNNNNNNN.NN	13	28	
TOTAL_AMOUNT	N	NNNNNNNNN.NN	13	41	

* AN – AlphaNumeric
N – Numeric (0 – 9 or decimal point (.) permitted)

Detail Line(s)

- Must have at least one (1) detail line between the header line and the trailer line
- Line Layout

Description	Type*	Format	Length	Start Position
PROVIDER_ID	AN	XXXXXXXXX	9	1
SERVICE_LOCATION	AN	XX	2	10
CONTRACT_NUMBER	AN	XXXXXXXX	8	12
CONSUMER_ID	AN	XXXXXXXXXX	10	20
CONSUMER_LAST_NAME	AN	XXXXXXXXXXXXXXXX	16	30
CONSUMER_FIRST_NAME	AN	XXXXXXXXXXXXX	13	46
SERVICE_START_DATE	AN	MM/DD/YY	8	59
FILLER_BLANK_1	AN		1	67
SERVICE_END_DATE	AN	MM/DD/YY	8	68
FILLER_BLANK_2	AN		1	76
SERVICE_CODE	AN	XXX	3	77
FILLER_BLANK_3	AN		1	80
DELIVERED_UNITS	N	NNNNNNN.NN	10	81
FILLER_BLANK_4	AN		1	91
ABSENT_UNITS	N	NNNNNNN.NN	10	92
FILLER_BLANK_5	AN		1	102
TOTAL_UNITS	N	NNNNNNN.NN	10	103
FILLER_BLANK_6	AN		1	113
RATE	N	NNNNNNN.NN	10	114
FILLER_BLANK_7	AN		1	124
TPL_AMOUNT	N	NNNNNNN.NN	10	125
FILLER_BLANK_8	AN		1	135
TOTAL_AMOUNT_DUE	N	NNNNNNN.NN	10	136
FILLER_BLANK_9	AN		1	146
BILLING_MONTH	AN	AAA	3	147
BILLING_FISCAL_YEAR	N	NN	2	150
FILLER_BLANK_10	AN		1	152
FILLER_BLANK_11	AN		1	153
PROVIDER_CONTROL_NUMBER	AN	XXXXXX	6	154
FILLER_BLANK_12	AN		1	160
PROVIDER_OF_SERVICES	AN	XXXXXX	6	161
SERVICE_CODE_REAL	AN	XXX	3	167
PLACE_OF_SERVICE	AN	XX	2	170
FILLER_BLANK_13	AN		3	172
TPL_CODE	AN	XX	2	175

* AN – AlphaNumeric
N – Numeric (0 – 9 or decimal point (.) permitted)

File Validation:

- ✓ Files that contain no errors will be automatically accepted into the PBS.

- ✓ Files with Header or Syntax errors will be automatically denied.

- ✓ The user will have the opportunity to replace, combine, or deny files that have an existing approved file (for the provider, month, and year).

- ✓ Header Checks
  - Provider Code in filename must be valid in Provider table and link to Provider ID in header file record.
  - Month and Year in filename must match the Month and Year in header file record (except for resubmissions RB <> RS).
  - Month and Year in header file record must match the Month and Year in detail file records.
  - Provider ID in header file record must match the Provider ID in detail file records.
  - Sum of Total Units, TPL Amount, and Total Amount in detail file records must match Total Units, TPL Amount, and Total Amount in trailer file record.
  - Record Count in trailer file record must be a valid numeric and in correct format (see layout).
  - Total Units, TPL Amount, and Total Amount in trailer file record must be valid numerics and in .correct formats (see layout).
  - Start Date and End Date must fall within the provider's start date and end date (in Provider table).

- ✓ Syntax Checks
  - Numeric fields (Delivered Units, Absent Units, Total Units, Rate, TPL Amount, Total Amount) must have decimal point (.) in correct location (see layout) and must not be blank.
  - Date fields (Start Date, End Date) must have slashes (/) in correct locations (see layout).

- ✓ Data Checks
  - Numeric fields (Delivered Units, Absent Units, Total Units, Rate, TPL Amount, Total Amount) must be valid numerics.
  - Date fields (Service Start Date, Service End Date) must be valid dates.
  - Start Date must be earlier than the End Date.
  - All detail file records must contain consumer-related services (i.e. Consumer Id <> 0000000000, blank)
- ✓ Warnings
  - Blank lines found in file are ignored during validation and are not sent to mainframe.

Common Errors

The following errors have been identified in initial vendor file submissions:

- No blank number fields should be transmitted. 0.00 should be transmitted instead of a blank.
- All consumer ids must have leading 0's. The file cannot pass the import routine without them.